

## International claim form

### Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

### How to complete this form

1. **Kindly complete this form when claiming for any medical expenses incurred while travelling overseas**
2. Use black ink. Print clearly with one letter per block
3. To avoid administration delays, kindly ensure this form is completed in full
4. Submit all medical claims and supporting documentation (Proof of payment per medical invoice and Proof of travel copy of ticket or passport)
5. You are required to report/submit all claims within 60 days of your return to South Africa or within 5 months, should you be living outside the borders of SA
6. Please attach a copy of your passport with entry and exit stamps or air tickets
7. To submit your claim, kindly e-mail to [claims@bankmed.co.za](mailto:claims@bankmed.co.za) or fax to **021 527 1940**
8. To follow up, contact **0800 BANKMED (0800 226 5633)**

### 1. Travel and personal information

Membership number	<input type="text"/>	Reference number	<input type="text"/>
Departure date	<input type="text"/>	Return Date	<input type="text"/>
Did you purchase your ticket by credit card?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Should you have indicated yes, kindly supply the name of your bank	<input type="text"/>		
Do you have medical cover in your current place of residence?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Patient's surname	<input type="text"/>		
Patient's first name(s)	<input type="text"/>		
Patient's date of birth	<input type="text"/>		
Postal address	<input type="text"/>		
	<input type="text"/>		
			Code <input type="text"/>
Physical address	<input type="text"/>		
	<input type="text"/>		
			Code <input type="text"/>
Telephone (Work)	<input type="text"/>	Fax	<input type="text"/>
(Home)	<input type="text"/>	Cellular	<input type="text"/>
E-mail	<input type="text"/>		

## 2. Details of medical aid related expenses incurred

Date of illness/injury/admission to hospital 

Y	Y	Y	Y	M	M	D	D
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Y	Y	Y	Y	M	M	D	D
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Y	Y	Y	Y	M	M	D	D
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Country of illness/injury

Cause of illness/injury/diagnosis/symptoms

Treatment or medication received

Full name of Healthcare Professional consulted

Name of hospital

Total amount claimed in foreign currency 

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eg US dollars, Cipriate pounds

Did you settle these accounts yourself? Yes  No

## 3. Declaration

I declare that the above particulars are true in every respect.

Names in full

Signature

Date 

Y	Y	Y	Y	M	M	D	D
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Do not sign incomplete forms